**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**
KINGWOOD MEDICAL CENTER
C/O HOLLAWAY & GUMBERT
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

**Carrier's Austin Representative Box**
#19

**Respondent Name**
AMERICAN HOME ASSURANCE CO

**MFDR Date Received**
JUNE 23, 2008

**MFDR Tracking Number**
M4-08-6324-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary Dated June 20, 2008:** "…Kingwood Medical Center billed its usual and customary charges for its services…The claim presented by Kingwood Medical Center was billed in the same manner and at the same rates that it would bill any health plan, insurer, or other medical bill payor…Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...the fees paid by AIG Domestic Claims, Inc., Inc. on behalf of American Home Assurance Company do not conform to the reimbursement section of Rule 134.401…it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

**Amount in Dispute:** $43,446.84

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary Dated July 11, 2008:** "Initially, the health care provider failed to file sufficient documentation for reimbursement. However, upon re-submission to Carrier, sufficient documentation was submitted to allow the Carrier to pay an additional amount of $39,475.99."

**Responses Submitted by:** Hoffman Kelley

## *SUMMARY OF FINDINGS*

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 2, 2007 through August 24, 2007 | Inpatient Hospital Services | $43,446.84 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital for the date of admission in dispute.
    - Effective July 13, 2008, the Division's rule at former 28 Texas Administrative Code § 134.401 was repealed. The repeal adoption preamble specified, in pertinent part: "Section 134.401 will continue to apply to reimbursements related to admissions prior to March 1, 2008." 33 Texas Register 5319, 5220 (July 4, 2008).
    - Former 28 Texas Administrative Code § 134.401(a)(1) specified, in pertinent part: "This guidelines shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the Effective Date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act." 22 Texas Register 6264, 6306 (July 4, 1997).
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- BILL TOTAL: $89,492.81 - PREVIOUS PMNT $23,672.77
- MCA RECONSIDERATION: HCA RESUBMITS BILL, REQUESTING PMNT AT 75%, AS CHARGES EXCEED $40,000 STATES ADDTL PMNT DUE $43,446.84.
- BILLING FOR FACILITY FEE, INPATIENT 22 DAYS, MULT LAB CHARGES, CT SCAN, O.R. SERVICE, P.T., O.T. **NO RECORDS SUBMITTED WITH INITIAL OR CURRENT BILLING.**
- CLAIM FILE RESEARCH FINDS PRE-AUTH #803751 & 803994 FOR INPATIENT EPIDURAL BLOCK, P.T., & MUA LT FOOT; MINOR PROCEDURES PERFORMED:
  8/2 admission for aggressive pain mgmnt & physical therapy
  8/2 tunneled epidural cath, lumbar, sympathetic block; MUA LT foot
  8/7 removal
  8/9 RT ANTECUBITAL PICC LINE
  8/11 CT scan lumbar spine
  8/22 aspiration back hematoma, neg culture
  8/24 discharged with IV antibiotics x 4 weeks
- Previously reimbursed ACIHFG surgical per diem X 22. Addtl pmnt for CT scan. Net pmnt per RockPort PPO. Rev Code 300 venipuncture charges, not separately reportable.
- With file documentation of minor surgery procedures, P.T., & pain management only, and in absence of any provider—submitted documentation to support billed procedures/supplies/medications & / or unusually extensive or costly services, stop loss reimbursement not allowable at this time.
- REV CODE 301 DURG SCREEN CHARGES NOT COMPENSABLE BY WORKERS COMP; PROVIDER MAY SUBMIT THESE FEES TO PATIENT EMPLOYER FOR PMNT.
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 96 – NON-COVERED CHARGE(S).
- 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION.
- 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE
- 5040 – PLEASE CONTACT EMPLOYER DIRECTLY FOR PAYMENT OF DRUG SCREENING CHARGES. DRUG SCREENING CHARGES ARE NOT REIMBURSED BY THE CARRIER/TPA.
- PPO REDUCTION: USAMCO-WIN/Rockport

**Issues**

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

**Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A)(v) of that same section states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $89,492.81. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to demonstrate that the particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c)(6).

4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
   (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
   (ii) the hospital's usual and customary charges; and
   (iii) reimbursement as set out in section (c) of this section for that admission

   In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "PPO REDUCTION: USAMCO-WIN/Rockport." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier American Home Assurance Co. and Kingwood Medical Center prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $89,492.81.

In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." The length of stay was twenty two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of twenty two days results in an allowable amount of $24,596.00.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352,359)." A review of the submitted hospital bill finds that the requestor billed $2,818.00 for revenue code 352-CT Scan-Body. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 352 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $419.20/unit for Fentl/Ropivaine 100ML, $303.99/unit for Imipenem/Cilastatin SO, $403.77/unit for Levaquin 750MG/150ML, $258.92/unit for Aztreonam 1GM/D5W 50, and $49.76/unit for Clonidine 1000MCG/10ML. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

  The total reimbursement set out in the applicable portions of (c) results in a total of $24,596.00.

Reimbursement for the services in dispute is therefore determined by the lesser of:

| §134.401(b)(2)(A) | Finding |
|---|---|
| (i) | Not Applicable |
| (ii) | $89,492.81 |
| (iii) | $24,596.00 |

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of $63,148.76. Based upon the documentation submitted, no additional reimbursement can be recommended.

## Conclusion

For the reasons stated above, the division concludes that the services in dispute are not eligible for the stop-loss method of reimbursement, that a pre-negotiated rate does not apply, and that application of 28 Texas Administrative Code §134.401(c)(1), titled *Standard Per Diem Amount,* and §134.401(c)(4), titled *Additional Reimbursements*, results in the total allowable reimbursement. Based upon the documentation submitted, the requestor's Table of Disputed Services, and reimbursement made by the respondent, the amount ordered is $0.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | 05/07/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.